

FERTILITY CELEBRATIONS AND REPRODUCTIVE HEALTH BEHAVIOUR IN MBAISE, IMO STATE, NIGERIA

Introduction

One of the critical issues confronting Nigeria today is that of reproductive health hazards among persons of reproductive ages, particularly women, which hold serious implications for the socioeconomic development of Nigeria. Certain behaviours influenced by some socio-cultural factors, including reproductive health norms, are known to predispose these women to these hazards. For many women, identity and status are linked with childbearing, which makes it socially and personally difficult to regulate their reproductive practices through abstinence and contraception and maintain maternal health. Sivard (1985) states that the central issue in reproductive health problems is the status of women. This low status has led scientists like Worth (1989) to conclude that the ability of women to regulate their reproductive health is dependent on certain pre-existing conditions. These conditions include the existence/perception of relative sexual equality between men and women, options other than motherhood existing to define self-identity or self-esteem for women, among others.

In other words, reproductive health behaviour of women or their ability to regulate it is determined by certain social and cultural factors, which define gender power relations. These factors, according to Mariasy and Radlett (1990) are less tangible but hard to change. For instance, men make the decisions on family size and sexuality, while the identity and status of many women are linked with childbearing. In such situations where sexual intercourse, for women is inevitably associated with the risk of pregnancy and childbearing, the reproductive health of mothers is definitely threatened (Okeibunor, 2000). This study is thus primarily concerned with the impact of culturally defined and enforced gender roles, such as childbearing on the reproductive health behaviour of Mbaise women.

In Mbaise, identity and status of women are linked to childbearing. The climax of a woman's reproductive life, here, is marked by a traditional ceremony commonly referred to as *ewu-ukwu*. *Ewu-ukwu* is a traditional ceremony reserved only for women who have attained ten pregnancies in their reproductive life in Mbaise, Imo State of Nigeria. Most women have been socialized to look up to it with great enthusiasm so as to get recognition in society. Thus women in these societies have many children in quick succession. Unfortunately, no one thinks of the cost of this reproductive (child-bearing) health practice on the women and the influence of the existing gender norms on the practice. Studies have revealed that frequent childbirths in close intervals increase the susceptibility of women to reproductive health complication and increase the chances of maternal morbidity and mortality (Isiugo-Abanihe, 1995). It follows therefore that to improve reproductive health levels, basic information is needed to understand reproductive health behaviours and practices that increase risk of exposure to reproductive health hazards in Nigeria.

Some of the reflections of the hazards associated with the childbearing practices (reproductive health behaviours) of women in Nigeria are the incidence of maternal morbidity and mortality. World estimates have ranked maternal mortality in Nigeria among the highest. Though most Nigerian women give birth outside hospitals (Okafor and Rizzuto, 1994), thus making it difficult to get comprehensive list of maternal mortality in Nigeria, available hospital studies report rates between 800 and 1,500 deaths per 100,000 live births (FGN and UNICEF, 1989; Chukwudebelu, 1994; NGO Network for Health, 2001). This is far worse than what obtains in the developed nations of the world. The average rate for developed countries is 30 deaths per 100,000 live births (Starrs, 1987; Okafor and Rizzuto, 1994). Thus irrespective of the loss of data due to deliveries in non-hospital facilities, it can be concluded that the rate of maternal mortality in Nigeria is alarmingly high.

These deaths are attributable to a number of unsafe reproductive health practices. They result from preventable complications related to pregnancies and childbirth

(Chukwudebelu, 1994; Shehu, 1994; and Isiugo-Abanihe, 1995). This calls for practical steps at improving reproductive health behaviour and enhancing reproductive health levels in Nigeria. To reduce problems associated with pregnancy therefore Adamson (1993) among others recommend proper child spacing and the adoption of effective contraceptives for sexually active persons of reproductive ages.

However, recent policies and programmes designed in this direction have not been very successful. According to Okafor (1991) formal maternity services such as prenatal care, routine delivery and post-natal care as well as the management of pregnancy related complications are being under-utilized in Nigeria, due to a number of factors, which include distance, cultural beliefs, economy, and gender factors. At the same time, women especially those living in rural areas remain under served.

The situation is worse in the case of protection against reproductive health hazards. The campaigns for protected reproductive activities have remained unsuccessful. Nigeria is reputed for very low modern contraceptive usage rates (Fisher, *et al.*, 1992). Often, the women take to a number of unorthodox mixtures and techniques after sexual intercourse, such as drinking salt solution or wearing charms and amulets, which are within their control (Okeibunor, 1999). Women who use these are hardly conscious of the cost to their reproductive health. Worse still, these women cannot control the reproductive activities of their partners. They are unable to exercise choice on all events that surround or affect human reproductive behaviour including the use of contraceptives. This inability to regulate their reproductive activities could be linked to the societal value systems and norms about sexuality and inequality in gender power relations.

According to Ankrah (1994) "traditional gender roles often deny women the power to protect their health. Since many cultures consider female ignorance of sexual matters a sign of purity, young women are afraid to seek crucial reproductive health information and services. Even after marriage, many women are unfamiliar with their own reproductive anatomy, reluctant to talk about sex for fear of appearing loose..."

This is true of societies with male dominance ideology, and is typical of most Nigerian societies. In these societies gender roles are segregated and from childhood women are socialized into accepting their role as future mothers which include being "submissive to their male partners" (Mundigo, 1992).

Concern for reproductive health behaviours goes beyond pregnancy-related complications and outcomes. There is also the problem of sexually transmitted diseases. The Acquired Immune Deficiency Syndrome (AIDS) virus is the most recent and perhaps much more involving reproductive health problem. Messersmith, *et al.* (1994) reported that more than an estimated 500,000 adult Nigerians were infected with the Human Immunodeficiency Virus (HIV) and projected that by 1996 more than one million Nigerians will be infected with the virus. By 1999 an estimated 3.1 million Nigerians were living with HIV/AIDS (Adesioye, 1999). According to Derek-Briggs (1999), the number of HIV/AIDS infected persons is on a steady rise in Nigeria. Due to the spread of maternal AIDS, it is estimated that more than 10 million children under the age of 10 years will be orphaned during the next decade (Greenhalgh, *et al.*, 1992).

These pose serious social problems and implications for reproductive health and national development. Unfortunately the women cannot negotiate safe sex and positive reproductive health behaviour with their male counterparts, because of the traditional gender roles and low status of women (Ankrah, 1994).

It therefore follows that the necessary first step to tackling reproductive health issues in Nigeria lies in first understanding the existing gender relations in Nigeria and their influence on reproductive health behaviour. Variations may exist from society to society and among social groupings. It is however important to note that this has been largely ignored in previous family planning programmes designed to improve reproductive health in developing countries. In Nigeria, Tunisia, Malaysia, among others, men have been largely ignored in family planning issues, while women are expected to ensure positive reproductive health (Arokiasamy, 1980; Okpere, *et al.*, 1986; Coeytaux, 1989; Isiugo-Abanihe, 1994; Onuoha, 2000).

In the recent past, family planning and other reproductive health services have been largely the responsibility of the medical profession, which often approaches issues like fertility reduction as one of compliance with medical prescriptions and women are expected to follow doctor's orders. There has been total disregard for the needs of people, particularly women in poor nations, and the way their social existence affects their decisions about health and reproduction. These approaches have relied heavily on behavioural change models. These models take little account of the social context of sexual and reproductive health behaviour, a failing especially relevant to women from developing countries. These models assume that being more aware, concerned with, and knowledgeable of medical prescriptions and family planning will lead to sustained behavioural change. It should be noted that while these efforts may influence reproductive health, they are unlikely to account for the attitude of an Mbaise woman to childbearing and ensure sustainable change in her reproductive health behaviour if more direct attention is not given to the issues of gender and power that provide the social context of sexual and reproductive decision making. There is thus an urgent need to clarify these issues if reproductive health levels in Nigeria are to be improved.

Methodology

Study design and population

The study followed a single-round survey design. This has been found useful in descriptive and exploratory studies (Fisher, *et al.*, 1991; and Cleland, 1990), such as this. It provided a valid cross-sectional picture of the demographic characteristics and issues, among other advantages.

The study was located in Mbaise, Imo State, Nigeria. Mbaise community has an area of over 298 km², with a population density of about 2,000 persons per km². It is one of the highest populated rural areas in Nigeria (Uhegbu, 1987), as well as in the British Commonwealth of Nations (Njoku, 1978).

Mbaise is one of the most culturally distinct rural communities in Imo State of Nigeria, with an alarmingly high rate of procreation and reproductive health behaviour, which aggravates reproductive health problems. Generally, Mbaise people delight in having large families with a high premium placed on the number and sex composition of children a man has (Igbo, 1997). The more the children in the family, the higher the status and prestige the family has, and vice versa. The value and status of an Mbaise woman is thus linked to the number and sex of children she can produce for her husband. Those with large number of children, for instance ten births, are commended with a ceremony referred to as *ewu-ukwu*. *Ewu-ukwu* literally means 'goat for the waist'. Before this, the woman is shown appreciation for having the ninth birth with *okuko-ukwu*, that is 'chicken for the waist' ceremony, while *ewu-ukwu* is the climax of it all. The *ewu-ukwu* tradition, which glorifies the arrival of the tenth child to one woman, has generated an infectious enthusiasm that borders on the enthronement of reproductive health behaviours and leave women vulnerable to reproductive health hazards.

Mbaise community consists of three local government areas (LGAs), namely Aboh-Mbaise, Ahiazu-Mbaise and Ezinihitte. Ezinihitte was randomly selected for this study. According to the 1991 population census, Ezinihitte had a total population of 91,919 made up of 42,568 males and 49,351 females (Federal Republic of Nigeria, 1992). This is projected to be 121,508 in 2001. This study is limited to the population of persons aged 15 years and above, which constitutes only 64,399 persons or about 57 per cent of the entire population. The target populations for the study are women and men of reproductive ages; women (15-49 years) and men (15-64 years), who are currently married.

Sample Size and Sampling Procedure

1. Sample Size

Five hundred respondents, approximately one per cent of the target population, constituted the sample for this study. This sample size was considered large enough and adequate to permit the

statistical computation and sub group comparisons called for in this study.

2. *The Sampling Procedure:*

Since Ezinihitte LGA is made up of several towns, villages and households, the multi-stage sampling approach was used to select towns, villages and household as well as respondents for the study. The simple random (ballot) sampling approach was used in selecting one town, namely Onicha, and five villages (Umuevu, Umuelagwa, Umubo, Umuhu and Umuoma). Each chosen village was assigned 100 respondents, that is 50 males and 50 females.

To get the respondents, one village route was randomly selected at the village square. The chosen village route was followed and the households along the route listed. For any household to be eligible for the study, there had to be at least one married couple resident in it at the time of the study. In such a household, the husband or wife was studied. When one route was exhausted without reaching the required number, another route was randomly selected for more respondents. This process was repeated until the desired number was achieved. This is cluster sampling, which is considered more amenable to homogenous population like Ezinihitte.

Instruments of Data Collection

The major instrument chosen for the purpose of collecting data for the study was the questionnaire. This is because in testing the study hypotheses, there was need for measurable statistical conclusions, which will lend themselves to easy quantitative comparison with the situation analysis of other communities. However, some qualitative data were ensured through the use of focus group discussions (FGDs) and in-depth interviews. These are considered necessary to give some contextual meaning to the quantitative findings in the study, as well as provide some vital information, which the questionnaire was weak in collecting. The in-depth interviews provided information from the aged persons and opinion leaders who are custodians of the people's culture.

For the quantitative data, a uniform set of questionnaire was administered to all the respondents, with only a few sex-specific issues incorporated for the different sex categories of respondents. The questionnaire sought information on the socio-demographic characteristics of the respondent, their childbearing practices and experiences. Specifically, it collected information on their reproductive health behaviour, and their belief system on reproductive health issues. Other issues included their perceived roles of women *vis-à-vis* their men folks.

The FGDs and in-depth interviews were conducted with carefully developed FGD and in-depth interview guides. These contained diagnostic questions on some of the issues raised in the questionnaire study. This was meant to provide in-depth knowledge of the socio-cultural risk factors of the communities with regards to reproductive health issues.

Methods of Data Collection

To ensure uniformity in interpretation of concepts and recording of responses, the questionnaires were administered in face-to-face (other-administered) interview with all the respondents. For this purpose field assistants were recruited and trained on the objectives and methods of the study. Same-sex interviews were carried out to prevent any cultural barriers and permit free discussion of issues.

For the qualitative data, a total of nine FGDs were conducted with eight persons in each group. The discussions were held with males and females, who were segregated by age into a young group (15-25), a middle group (26-39) and an old group (40 and above). Discussions were held with homogenous groups, and the moderator was of the same sex with each group.

Participants in the FGDs were purposively selected from persons within the age group, who were not interviewed in the questionnaire study. However, the in-depth interviews targeted a special group of opinion/community leaders, (stakeholders and gatekeepers in the reproductive health of women), who were not included in the questionnaire study.

Results

Sociodemographic Information

The ages of the respondents ranged from 15 to 64 and 15 to 49 years for male and female respondents respectively. The modal age ranges of 40-44 years and 35-39 for the male and female respondents respectively were also shown in Table 1. The respondents came from different religious, educational and occupational backgrounds.

Reproductive Health Behaviour/Reproductive Norms

Eighty five per cent of the respondents perceived, that in childbearing, men are traditionally expected to decide the number of children to have in the family. Others (5.3% and 9.7%) were of the opinion that what is traditionally expected of men in childbearing is to train the children and provide food for the household respectively.

A segregation of the data by sex shows that there is no difference in the traditional expectation by sex. About 83 per cent of the females and 87 per cent of the males subscribed to this view. This shows a deep-seated normative system that favours the males in the society. In-depth interview with opinion leaders and FGD data was corroborated this finding. In a reaction that betrayed some surprise about the question on the expected role of men in childbearing, participants in FGD session with adult males, aged 40 years and above agreed that,

"...the man makes the decision on the number of children to have in the family and also trains the children" (a participant in an FGD session with men aged 40 years and above in Umuelegwa).

The leader of the Catholic Women Organization in Umuevu pointed to the logic in this. According to her,

"the women only bear the children. The man, who is the head of the household, makes decision on the family income and knows how many children he can support. So his expected role in childbearing is to decide the number of children to have especially in the present times of economic hardship".

A member of the Catholic Men's Organization, who was also interviewed as an opinion leader, argued that,

"...traditionally, there was no need to make decisions on the number of children to have. Then the role expected of men in childbearing was to train the children given by God to know God and their parents; send them to school and feed them. These days, we are advised to plan our families. It is the man that takes the decision to plan or not to plan depending on what he wants".

The results also show that contrary to the case of the men, women are traditionally expected to produce the number of children desired by the husband. This view was held by 78.5 per cent of the persons interviewed. Interestingly, this view did not differ when checked for the different sexes. Results like this have led Olusanya to conclude that,

"...one common feature to them (African societies) is the strong emphasis on, or obsession with, the females' procreative function primarily for the perpetuation of the family and lineage. The social pressures arising from this obsession have from childhood so conditioned the female into a kind of demographic martyr that she has come to believe very strongly that it is a matter of life and death to bear children (Olusanya, 1989)".

Table 2 shows some other roles which respondents expected of the women with respect to childbearing in the household. Women were only to service the "well-set" machinery put in place by the man to ensure the continued existence of his family. The man decides on the number and training of the children while the woman plays mainly a maintenance role. She "obeys the husband's wish" by producing the number of children he desires (10.5%), "takes care of the children" (7.7%) and "takes care of the family" (3.2%). No mention was made of her role in training the children. This situation led Adedokun (2000) to posit that, "of the many roles performed by women in Nigeria, the best acknowledged is their childbearing role". Unfortunately, this is a cultural bias that has not only limited the expectation of even the women of themselves but has also encouraged early marriage, and the desire of women to have many children even to the detriment of their reproductive health.

Both in-depth interviews and the FGDs revealed that the major role of women in the household is childbearing. According to one of the participants in the FGD with adult females aged 40 years and above, in Onicha-Ezinihitte-Mbaise,

"the major role of a woman in this community is to have children because if she has children without doing the housework she will be more tolerable than the one who has no children and does plenty work".

This is typical of the attitude of the various groups in the different communities studied. Another example is to be seen in the argument of another woman, in the same group referred to above (women aged 40 years and above in Onicha-Ezinihitte-Mbaise), when she was asked if she agreed with this view. She said,

"yes now! Come to think of it, a woman without children... you know, I agree. I agree o, childbearing is our major role here".

All the groups irrespective of age and sex shared this view. According to a participant in an FGD session with young females aged 26-39,

"...the prayer of every woman is that she should have children for her husband. If her marriage is not blessed with children she will be unhappy because the husband may hate her. Even the parents-in-law will keep disturbing her to provide them with their grand children before they die".

Another participant in the same group pondered,

"...in all seriousness, let us keep modernization out of this, which married woman will not want to prove her womanhood?. You can only prove it by having children for your husband. Some people say marriage is for companionship. Just try it here and somebody will tell you where you belong. The number one role of the woman is to have children."

Similarly, all the opinion leaders interviewed held the same view on the major role of women in the household. According to a female opinion leader in Umuoma,

" why would my sons marry if not to give me grand children? That is the major role of women otherwise there is no need for marriage. People can remain in their father's house without marriage."

A male community leader, a retired schoolteacher and village Chief, in the same community wondered why God created the institution of marriage. For him,

" ...it is to procreate in an orderly manner without chaos. And it is the wife, not the husband that can get pregnant and bear children in the orderly arrangement called marriage".

On the things considered normal with respect to number of children one could have in a lifetime, in the past, it was generally contended that it was normal to have more than ten children. This was supported by virtually all (99.2%) of the persons interviewed. See Table 3.

In an FGD with women aged 40 years and above, it was contended that,

" ...women are expected to fill the house with children".

For this, another woman in the same group opined that,

" she (a woman that fills the house with children) gets compensated and honoured with a goat, 'ewu-ukwu' if she is able to produce as many as ten children. Before that, at the ninth birth a fowl, 'okuko ukwu".

A participant, in an FGD session with women aged 26-39 years, was quick to add, when a question was put forward to confirm this view that,

" while the 'ewu-ukwu' is killed for the woman another goat is also slaughtered for the man in recognition of his masculinity and ability to make the woman achieve that height of having so many children".

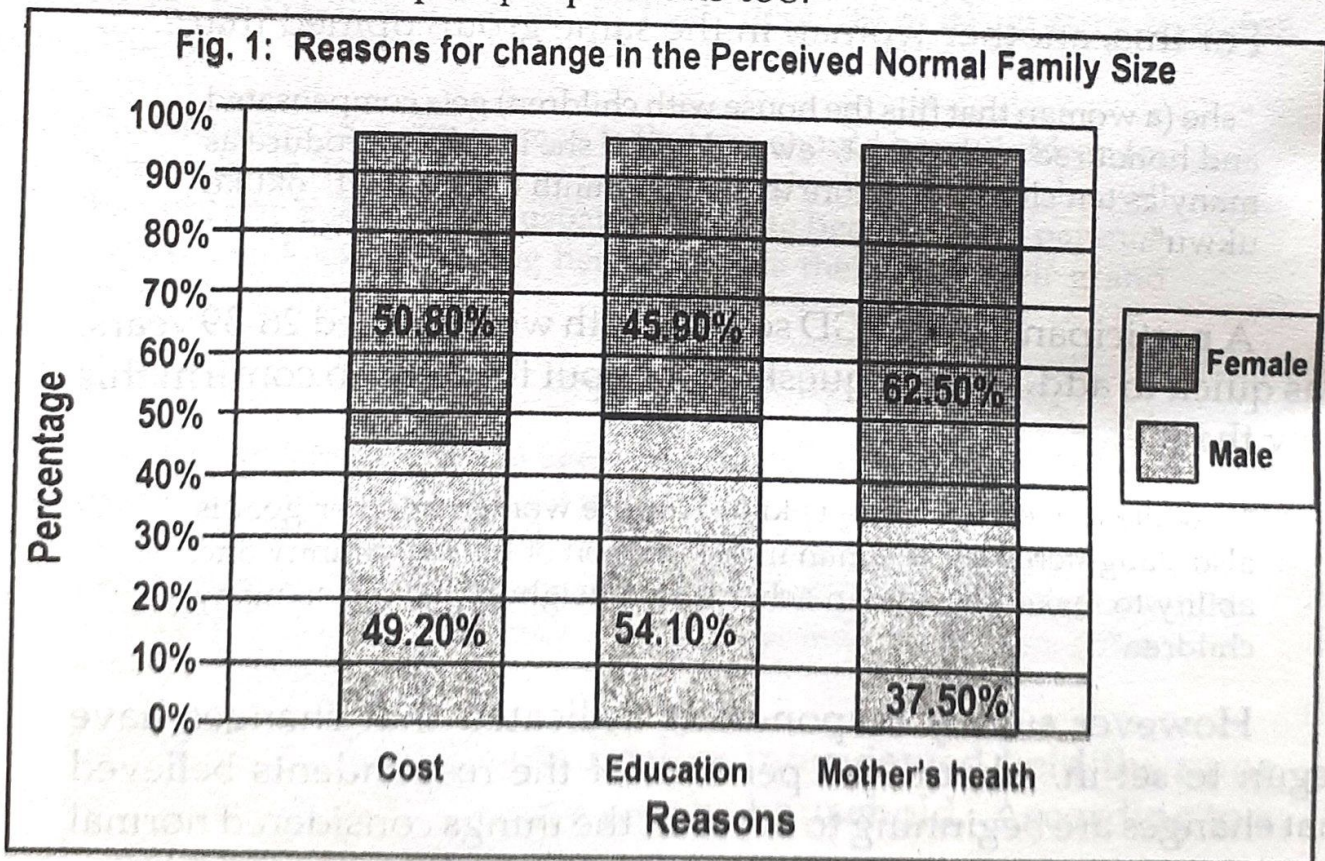
However survey respondents indicated that changes have begun to set in. About 92.0 per cent of the respondents believed that changes are beginning to occur in the things considered normal with respect to the number of children one could have in a lifetime.

The data show also that high proportions of both the male and female respondents (94.4% and 88.8% respectively) believe that changes are setting in. Similarly, in an in-depth interview with one of the opinion leaders (a male member of the Late Eze's cabinet and a traditional village leader in Umuevu) it was said, that,

"in these days, when you enter a house, children come out in droves to greet you but these days you find one or two of them whenever you go and they look lonely and afraid".

On the reasons for the suggested change, the respondents mentioned the cost of rearing the children (52.8%), education and modern life style involving change in attitude and values (31.5%) and the mother's health (3.4%) among other reasons. See Figure 1.

Interestingly, this finding did not differ when checked against the sex of the different respondents. About half of the females and males indicated that the increasing cost of childrearing is responsible for the change. Both the male and female respondents mentioned education and modernization (western lifestyle and change in values) in almost equal proportions too.



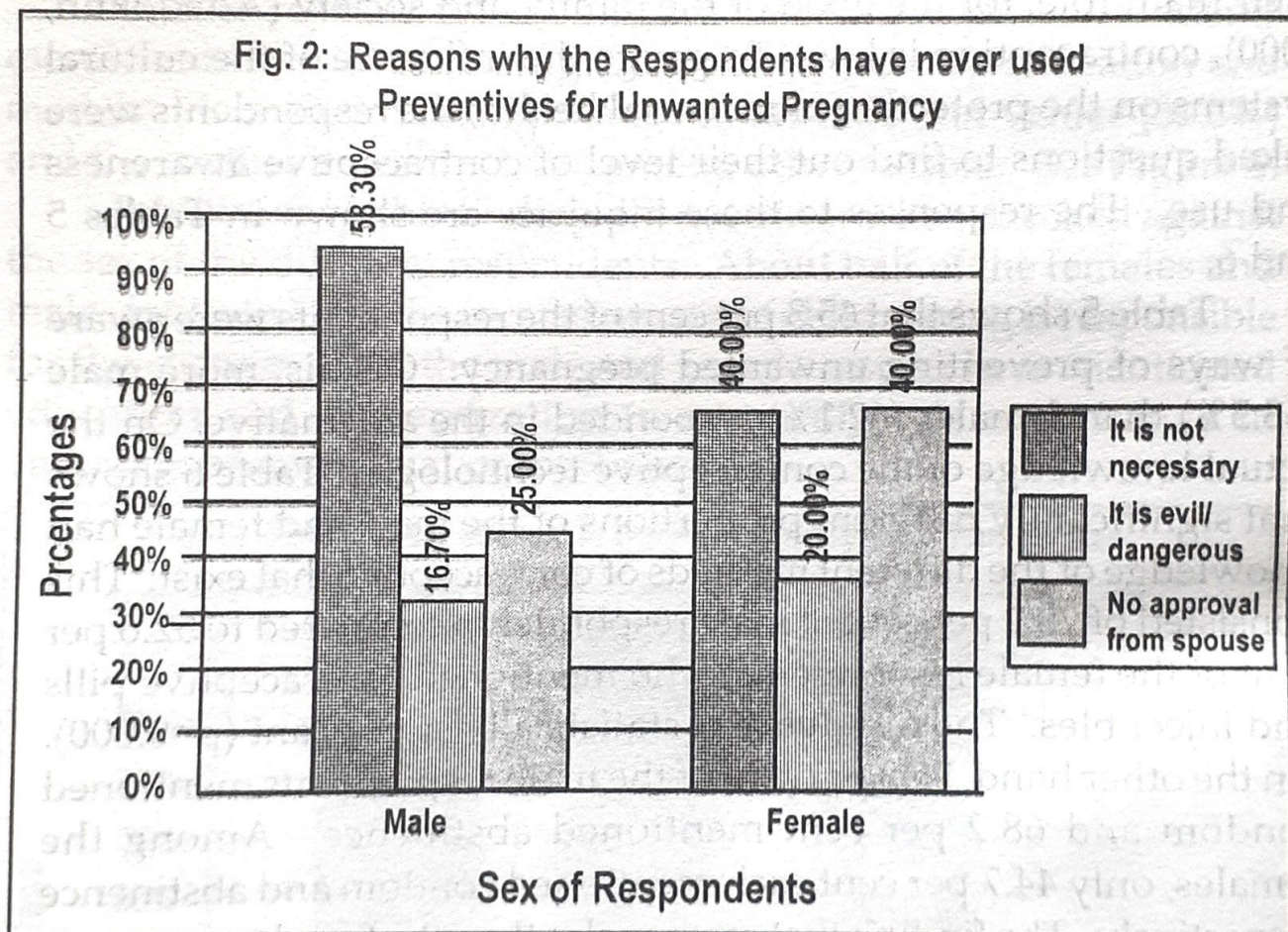
However, the Figure revealed a disproportional distribution with respect to the perception of maternal health as the reason for the envisaged change. The female respondents constitute 62.5 per cent of the respondents who felt the change is due to peoples' realization of the need to protect the mother's health, while the male respondents in the study constituted only 37.5 per cent. Perceptions like this affect the use of contraceptive technologies and the need for the protection of the reproductive health of mothers. In societies where women are seen to have the responsibility of childbearing as their main role, for the good of the family and society (Adedokun, 2000), contraception is low. To gauge the influence of the cultural systems on the protection of maternal health, the respondents were asked questions to find out their level of contraceptive awareness and use. The responses to these inquiries are shown in Tables 5 and 6.

Table 5 shows that 65.3 per cent of the respondents were aware of ways of preventing unwanted pregnancy. Of this, more male (68.5%) than females (62.1%) responded in the affirmative. On the actual knowledge of the contraceptive technologies, Table 6 shows that significantly different proportions of the male and female had knowledge of the different methods of contraceptive that exist. This consisted of 28.2 per cent of male respondents compared to 52.6 per cent of the female respondents, who mentioned contraceptive pills and injectibles. The difference is statistically significant ($p=0.000$). On the other hand, 55.3 per cent of the male respondents mentioned condom and 68.2 per cent mentioned abstinence. Among the females, only 44.7 per cent each mentioned condom and abstinence respectively. The finding that more males than the females are aware of condom and abstinence is also statistically significant (0.000).

This may be linked to the fact that these services are male directed techniques. For instance the condom is a male device, which depends on acceptability by the males. The females are not expected to know much about it. Similarly, abstinence as a method depends on the 'permission' of the man. Since the success of a woman is measured by the number of children she had for her

husband and satisfaction of the desire of the man, the resort to abstinence is personally and social impossible for women.

Ironically, more of the married women (68.4%) than the male counterparts (46.6%) have ever used the male condom. More of the male respondents' (61.6%) than the female respondents (31.6%) indicated that they have ever used abstinence as a way of preventing unwanted pregnancy. A further test to establish the statistical significance of these results, using the *Yates*_{corrected} X^2 revealed that the results are significant at $p < 0.001$ levels.



The results imply, however, that some of the respondents have never used some of the contraceptive techniques in the prevention of unwanted pregnancies for different reasons. These reasons also varied by sex of the respondents. For instance, among those who have never used contraceptives to prevent unwanted pregnancy, more of the male respondents (58.3%) than the female respondents (40.0%) think it is not necessary to use these methods. However, more of the female respondents (40.0%) than their male counterparts

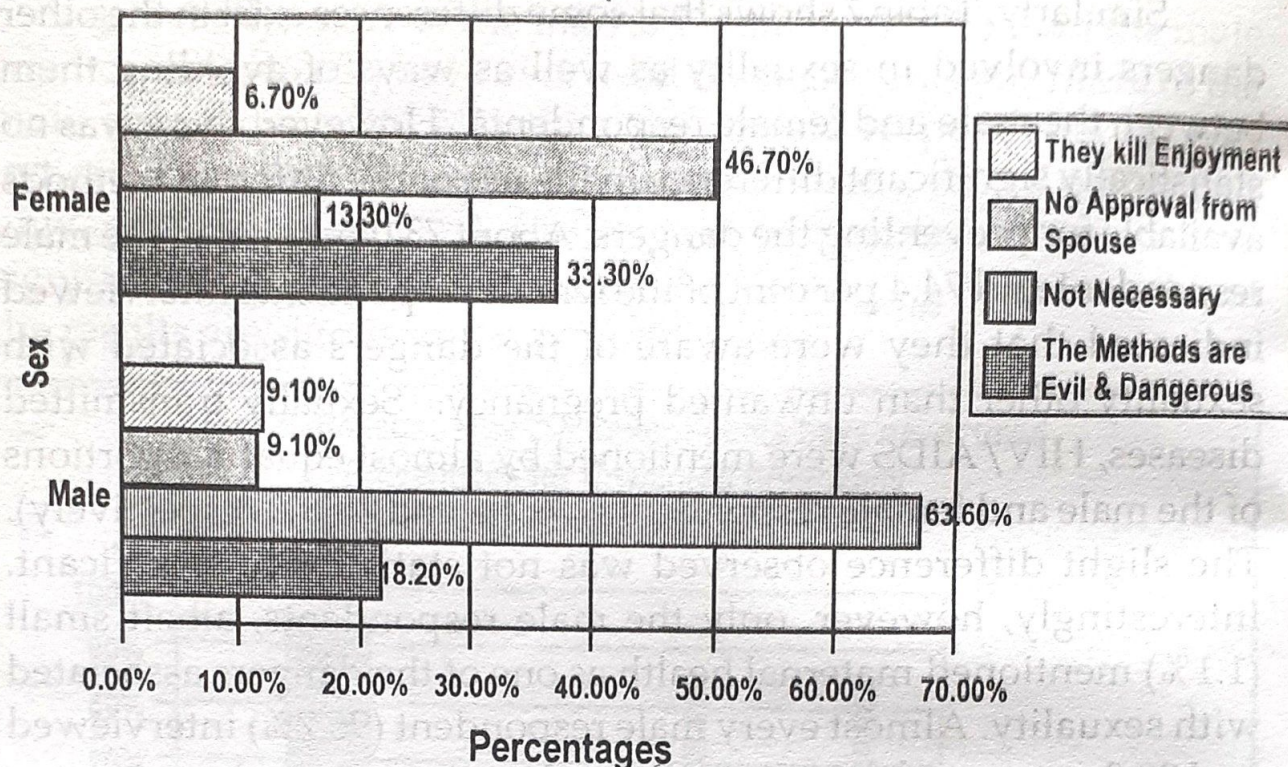
(25.0%) never used the methods they mentioned because they lacked approval from their spouses. (Figure 2)

Similarly, Table 7 shows that some differences exist in the other dangers involved in sexuality as well as ways of avoiding them between the male and female respondents. However, there was no statistically significant difference in the use of the different methods available for preventing the dangers. About 73.0 per cent of the male respondent and 74.4 per cent of the female respondents interviewed indicated that they were aware of the dangers associated with sexuality other than unwanted pregnancy. Sexually transmitted diseases, HIV/AIDS were mentioned by almost equal proportions of the male and female respondents (76.7% and 80.6% respectively). The slight difference observed was not statistically significant. Interestingly, however, only the male respondents, albeit small (1.1%) mentioned maternal health as one of the dangers associated with sexuality. Almost every male respondent (96.7%) interviewed and 80.0 per cent of the female respondents interviewed were aware of the ways of preventing the dangers. The *Yates*_{corrected} X^2 test for significance revealed that the difference is significant.

A number of devices were mentioned as ways of preventing these dangers in human sexuality. The ways included condom, which was mentioned by 88.5 per cent and 93.4 per cent of the male and female respondents respectively. Another method was abstinence, which was mentioned by 37.9 per cent of the male respondents and 53.9 per cent of the female respondents. Some of the males (2.3%) mentioned prayers.

On the use of these methods, almost equal proportions of the male and female respondents (87.4% and 85.5% respectively) had ever-used any of the methods mentioned. Similarly, almost equal proportions (32.9% and 38.5%) of the male and female respondents respectively had ever-used abstinence. Obviously, some of the respondents have never used any of the methods mentioned. The reasons for the non-use varied among the respondents and between sexes. These are reflected in Figure 3 below.

Fig. 3: Reasons for not using any preventive method against STDs among the Respondents

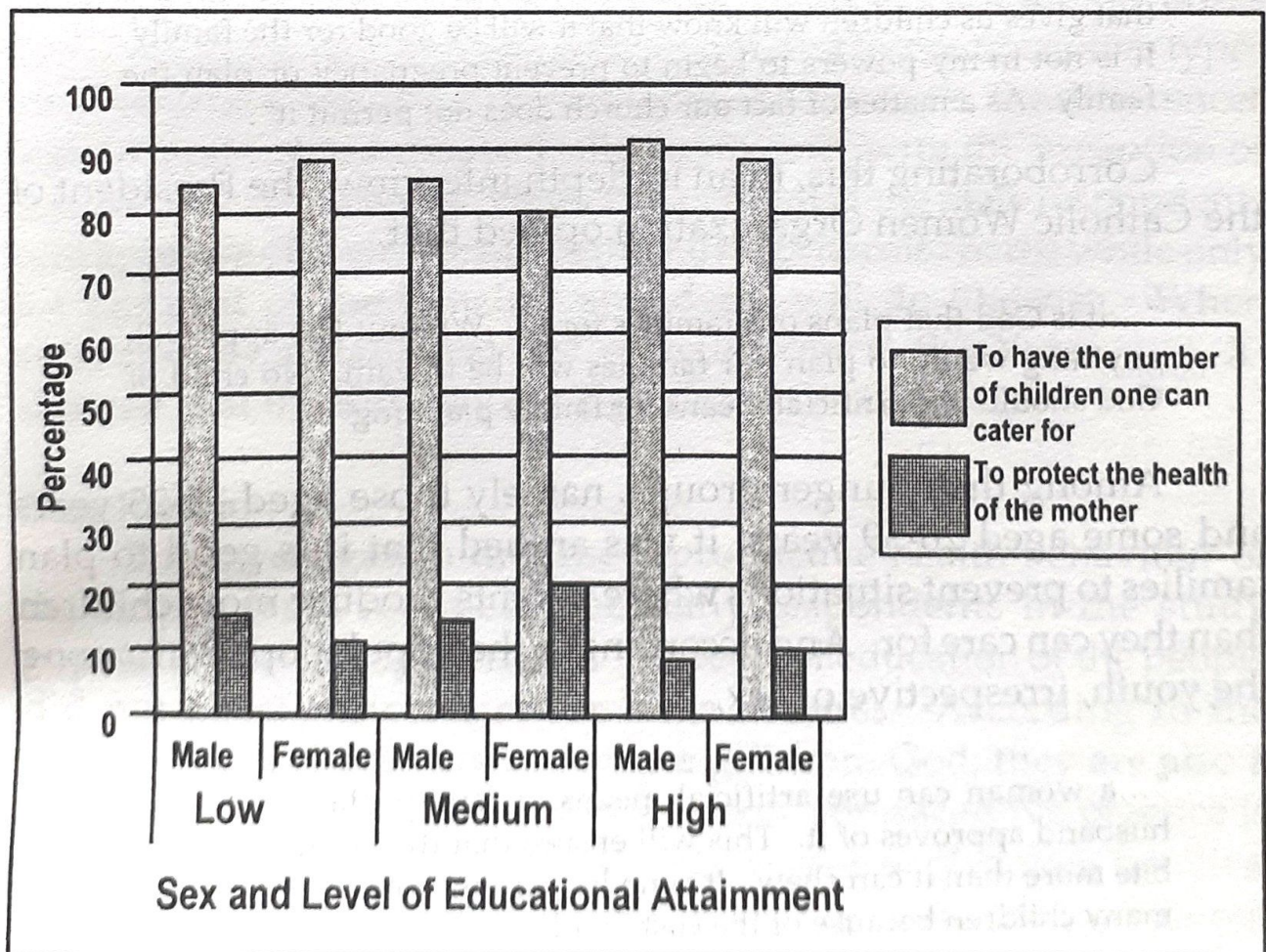


More male respondents (63.6%) than the female respondents (13.3%) indicated that they never used condoms because they kill enjoyment of sex. On the other hand, more of the female respondents than their male counterparts had never used any of the protective devices because of non-approval of their spouses. Furthermore, on the reproductive health behaviour of the respondents, Table 8 revealed that while three-quarters (76.6%) of the male respondents were willing to plan their family only 65.6 per cent of the females fell into this category. The reasons given by those who wish to plan their families included the need to have the number of children one can cater for (86.3% and 84.1% among the male and female respondents respectively). Very small proportions (13.7% and 15.9% respectively) of the male and female respondents indicated the protection of the health of the mothers as their reason. This points to the prominence given to male-specific logic. It has been noted that the men in the household were expected to provide money for running the home and training the children. This may then explain the concern for planning the family to have the number of children one can cater for.

Education had no impact on this finding as Figure 4 revealed that irrespective of the level of education attained by the respondents, very high proportions were willing to plan their families to get the number of children they can cater for. There was also no significant difference in the result when segregated by the sex of the respondents as shown in Figure 4.

The Table 8 shows reasons why some of the respondents did not wish to plan their families. The reasons included the belief that children were gifts from God, which was indicated by 72.4 per cent and 51.2 per cent of the male and female respondents respectively. More of the female respondents (20.9%) than the male respondents (6.9%) were also concerned about the approval from their spouse to plan their families.

Fig. 4: Reasons for Respondents' Willingness to plan their Families by Sex and Level of Educational Attainment



About 37 per cent and 49 per cent of the males and females respectively depended on family planning contraceptive pills for achieving the desire to plan their families. More than half (52.6%) of the male respondents and 31.7 per cent of the female respondents depend on abstinence. Slightly more than one-quarter (29.5%) and slightly less than one-quarter (24.3%) of the male and female respondents depended on God's help to be able to achieve their desire to plan their families. According to a participant in the FGD with women aged 26-39 years,

"Only God has the powers to protect you from unwanted pregnancy. For me I do not do anything about it. I just depend on God to let me have the number of children that is good for my family."

When the same woman was asked the number of children she thought would be good for her family, she retorted that,

"that is left for my husband to decide. But what I mean is that God that gives us children will know that it will be good for the family. It is not in my powers to begin to prevent pregnancy or plan the family. As a matter of fact our church does not permit it".

Corroborating this, in an in-depth interview, the President of the Catholic Women Organization opined that,

"...it is God that plans our families for us. Without His approval, anything we do to plan our families will be in vain. No child of God should use artificial means for family planning"

Among the younger groups, namely those aged 15-25 years and some aged 26-39 years, it was argued that it is good to plan families to prevent situations where parents produce more children than they can care for. And according to the popular opinion among the youth, irrespective of sex,

"...a woman can use artificial means of family planning if the husband approves of it. This will ensure that the family does not bite more than it can chew. It is no longer fashionable to have too many children because of the cost involved..."

Various scientists have implicated the process of decision-making as one of the major reasons for the lack of control and commitment over what happens in the reproductive health of women. It is envisaged that the bias against female decision-making encourage complacency in the protection of the female reproductive health by even women and as such endanger their lives while struggling to produce the number of children desired by their husbands.

The data show that about one-third of the respondents have never discussed number of children they want to have with their partners. And the reasons for this included the belief that culture gives all powers to do that to the men alone. This was mentioned by over two-thirds of the male and female respondent alike. Even in homes where discussions are held between spouses on the number of children they want to have, the husbands make the final decisions. About 9.3 per cent and 7.6 per cent of the males and females respectively mentioned this: The approval to use contraceptive material given by marital a partner for the purposes of preventing unwanted pregnancies differed by contraceptive types and between sexes of the respondents. All the same, the differences were found not to be statistically significant, with the exception of the use of charms/herbs. Here, 11.6 per cent of the male respondents will approve of their marital partner using charms/herbs while only 5.4 per cent of the female respondents will do likewise. When subjected to a statistical test of significance, the *Yates* ^{corrected} X^2 showed that the difference is significant at 0.03 levels.

Conclusion

The investigation into the reproductive health behaviour of the respondents revealed that many respondents in the study population desire high fertility. The level of education of the people did not affect their desire for large families. According to the respondents children are not only a gift from God, they are also a source of joy and wealth. For this reason, contraceptive practice is low. Many of the respondents would not wish to plan their families. Those who envisaged change in the normal desire for many children

only mentioned factors associated with the cost of rearing children as well as education and modernization as responsible for the change in family size desired. This was however affected by the sex of the respondents. Generally, these findings agree with some earlier propositions, theoretical viewpoints and empirical findings (Olusanya, 1989; Doan, 1994; Dixon-Mueller, 1996; Adedokun, 2000). Further they agree with the fact that the issue of asymmetry, that is double standards and inequities in the rights and responsibilities for men and women in sexuality has important implication for reproductive health behaviour of women in general and indeed Mbaise women, who are socialized into the traditional practices of ensuring the happiness of their male partners.

Men in Mbaise strive to prove their manhood while women remain passive and compliant, striving to fulfill the dream of the husbands by providing the number of children desired by their husbands. This drive for many children as a way of gaining higher status in community were found to cut across a number of sociodemographic factors. In the words of Mundigo (1998), "the traditional hold on power that men have had over the span of history has contributed to their sexual freedom, while, at the same time, instituting deep rooted gender-based inequalities that placed women in a disadvantageous position in the home..." It is however suggested that since gender has a dynamic nature, changes are possible with change in technological base of any society (Osuntimehin, 1999).

However, studies have identified that economic independence is an essential ingredient for the attainment of women's empowerment. Consequently, the empowerment model by Doan (1994) was used to support the sexuality-gender framework from Dixon-Mueller in analyzing the present study. A woman's power to make decisions sometimes increases with her level of education. It may also depend on her age. Generally, younger women who marry much older men have less power than women who marry someone closer in age (Balk, 1997; De Silva, 1994 and Gage, 1995).

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Level	Percentage	Percentage	Percentage
University Degree (ND)	13 (7.3%)	30 (17.2%)	30 (17.2%)
Diploma Cert. (OND/NGE)	52 (29.2%)	46 (18.1%)	46 (18.1%)
School Cert. (WASC/CE O/L)	58 (32.8%)	64 (32.8%)	64 (32.8%)
First School Leaving Cert.	64 (36.4%)	67 (33.2%)	67 (33.2%)
No Formal Schooling	62 (34.8%)	59 (29.8%)	59 (29.8%)
Occupation			
University Degree	13 (7.3%)	30 (17.2%)	30 (17.2%)
Diploma Cert.	52 (29.2%)	46 (18.1%)	46 (18.1%)
School Cert.	58 (32.8%)	64 (32.8%)	64 (32.8%)
First School Leaving Cert.	64 (36.4%)	67 (33.2%)	67 (33.2%)
No Formal Schooling	62 (34.8%)	59 (29.8%)	59 (29.8%)
Teaching	11 (6.3%)	62 (34.8%)	49 (28.0%)
Teaching (Sec)	11 (6.3%)	62 (34.8%)	49 (28.0%)
Business	52 (29.2%)	30 (17.2%)	32 (18.8%)
Unemployed/Student	48 (27.2%)	38 (21.4%)	0 (0.0%)
Religion			
Catholic	32 (18.8%)	184 (77.2%)	178 (71.2%)
Protestant	114 (25.9%)	22 (50.8%)	62 (27.8%)
African Tribal Religion (ATR)	14 (2.8%)	4 (1.0%)	10 (4.0%)

Table 1:
Showing the Sociodemographic Characteristics of Respondents

Age Group	Sex of Respondents		
	Male	Female	Total
15-19	2 (0.8%)	—	2 (0.4%)
20-24	—	8 (3.2%)	8 (1.6)
25-29	6 (2.4%)	22 (8.8%)	28 (5.6%)
30-34	8 (3.2%)	56 (22.4%)	64 (12.8%)
35-39	22 (8.8%)	76 (30.4%)	98 (19.6%)
40-44	58 (23.2%)	60 (24.0%)	118 (23.6%)
45-49	62 (24.8%)	28 (11.2%)	90 (18.0%)
50-54	38 (15.2%)	—	38 (7.6%)
55-59	24 (9.6%)	—	24 (4.8%)
60-64	30 (12.0%)	—	30 (6.0%)
Education			
No Formal Schooling	59 (23.6%)	62 (24.8%)	121 (24.2%)
First School Leaving Cert.	57 (22.8%)	54 (21.6%)	111 (22.2%)
School Cert. (WASC/GCE O/L)	58 (23.2%)	58 (23.2%)	116 (23.2%)
Diploma Cert. (OND/NCE/)	46 (18.4%)	58 (23.2%)	104 (20.8%)
University Degree/HND	30 (12.0%)	18 (7.2%)	48 (9.6%)
Occupation			
Farming/Fishing	50 (20.0%)	54 (21.6%)	104 (20.8%)
Wine Tapping	27 (10.8%)	—	27 (5.4%)
Civil Service	59 (23.6%)	22 (8.8%)	81 (16.2%)
Teaching	34 (13.6%)	46 (18.4%)	80 (16.0%)
Trading	49 (19.6%)	62 (24.8%)	111 (22.2%)
Business	22 (8.8%)	30 (12.0%)	52 (10.4%)
Unemployed/Student	9 (3.6%)	36 (14.4%)	45 (9.0%)
Religion			
Catholics	178 (71.2%)	194 (77.6%)	372 (74.4%)
Protestants	62 (24.8%)	52 (20.8%)	114 (22.8%)
African Tradi. Religion (ATR)	10 (4.0%)	4 (1.6%)	14 (2.8%)

Table 2:
Showing the Traditional Expectations of Men and Women in Childbearing as Perceived by the Respondents

Traditional Expectations of Men	Sex of Respondents		
	Male	Female	Total
Decide number of children to have in the family	216 (87.1%)	204 (82.9%)	420 (85.0%)
Train children	10 (4.0%)	16 (6.5%)	26 (5.3%)
Provide for household	22 (8.7%)	26 (10.6%)	48 (9.7%)
Traditional Expectations of Women			
Produce the number of children desired by husband	198 (79.8%)	190 (77.2%)	388 (78.5%)
Obey husband's wishes	24 (9.7%)	28 (11.4%)	52 (10.5%)
Take care of children	16 (6.5%)	22 (8.9%)	38 (7.7%)
Take care of the family	10 (4.0%)	6 (2.4%)	16 (3.2%)

Table 3:
Showing the Things Considered Normal with Respect to Number of Children One Can Have in a Lifetime, in the Past

Things that were considered normal in the past	Sex of Respondents		
	Male	Female	Total
To have more than ten children	248 (100%)	244 (98.4%)	492 (99.2%)
To have the number one can train	—	4 (1.6%)	4 (0.8%)
Total	248 (100%)	248 (100%)	496 (100%)

Table 4: Showing Any Changes in the Things that were Considered Normal with Respect to Number of Children one Could Have in a Life-time, in the Past

Any changes in things that were considered normal in the past, on family size	Sex of Respondents		
	Male	Female	Total
Yes (there are change)	234 (94.4%)	222 (88.8%)	456 (91.6%)
No (there are no change)	14 (5.6%)	28 (11.2%)	42 (8.4%)
Total	248 (100%)	250 (100%)	494 (100%)

Table 5: Showing Awareness of Ways of Preventing Unwanted Pregnancy

Awareness of Ways of Preventing Unwanted Pregnancy	Sex of Respondents		
	Male	Female	Total
Yes	170 (68.5%)	154 (62.1%)	324 (65.3%)
No	76 (31.5%)	94 (37.9%)	172 (34.7%)
Total	246 (100%)	250 (100%)	494 (100%)

Table 6: Showing Ways of Preventing Unwanted Pregnancies Known and Ever-Used by Respondents

Variables	Sex of Respondents		P-value for Yates corrected χ^2
	Male	Female	
Ways of Preventing Unwanted Pregnancy			
Contraceptive Pills and Injectibles	n=170 48 (28.2%)	n=152 80 (52.6%)	0.00001
Condom	94 (53.3%)	76 (50.0%)	0.000001
Abstinence	116 (68.2%)	68 (44.7%)	0.00004
Charms/herbs	6 (3.5%)	8 (5.3%)	
Ways Ever-used in Preventing Unwanted Pregnancy			
Contraceptive Pills and Injectibles	n = 146 6 (4.1%)	n = 114 42 (36.8%)	0.00000
Condom	68 (46.6%)	78 (68.4%)	0.001
Abstinence	90 (61.6%)	36 (31.6%)	0.000002
Charms/herbs	4 (2.7%)	-	

Table 7:
Showing Respondents' Awareness of Other Dangers Associated with Sexuality, Ways of Preventing Them and Ever-use of These Ways

Variables	Sex of Respondents		
	Male	Female	P-value for Yates _{corrected} X ²
Aware of Dangers Associated with Sexuality:			
* Yes	180 (72.6%)	186 (74.4%)	N.S.
* No	68 (27.4%)	64 (27.4%)	
Listed Dangers:			
* Sexually Transmitted Disease (STD)	138 (76.7%)	150 (80.6%)	N.S.
* HIV/AIDS	96 (53.3%)	100 (53.8%)	N.S.
* Maternal Health	2 (1.1%)	-	N.S.
Aware of Ways of Preventing Dangers:			
* Yes	174 (96.7%)	154 (93.4%)	0.00002
* No	6 (3.3%)	32 (17.2%)	
Mention Ways of Preventing Danger:			
* Condom	154 (88.5%)	142 (93.4%)	N.S.
* Abstinence	66 (37.9%)	82 (53.9%)	0.01
* Charms/Herbs	8 (4.6%)	4 (2.6%)	N.S.
* Prayer	4 (2.3%)	-	N.S.
Ever-used Any?:			
* Yes	152 (87.4%)	130 (85.5%)	
* No	22 (12.6%)	22 (14.5%)	N.S.
Types Used:			
* Condom	116 (76.3%)	108 (83.1%)	N.S.
* Abstinence	50 (32.9%)	50 (38.5%)	N.S.
* Charms/Herbs	2 (1.3%)	-	N.S.
* Prayer	-	4 (3.1%)	N.S.

N.S. = Not Significant

Table 8: Showing Respondents' Attitude to Family Planning

Attitude	Sex of Respondents		P-value for Yates _{corrected} χ^2
	Male	Female	
Are you willing to plan your family?			
* Yes	190 (76.6%)	164 (65.6%)	0.01
* No	58 (23.4%)	86 (34.4%)	
If yes, why?			
* To have number of children one can cater for	164 (86.3%)	138 (84.1%)	N.S.
* To protect the health of the mother	26 (13.7%)	26 (15.9%)	
If no, why?			
* It is not necessary	6 (10.3%)	16 (18.6%)	N.S.
* Children are gift from God	42 (72.4%)	44 (51.2%)	
* Partner does not like it	4 (6.9%)	18 (20.9%)	
* Many children are a source of joy	4 (6.9%)	8 (9.3%)	
* Others	2 (3.4%)	—	

N.S. = Not Significant

Table 9: Showing Family Size Decision Making Process

Process	Sex of Respondents		P-value for Yates _{corrected} χ^2
	Male	Female	
Have you ever discussed number of children to have with your partner?			
* Yes	172 (69.4%)	158 (63.2%)	N.S.
* No	76 (30.6%)	92 (36.8%)	
If no, why?			
* Not necessary	22 (29.0%)	18 (19.6%)	N.S.
* Husband has no time for such talk		2 (2.2%)	N.S.
* The culture gives all powers to the man	54 (71.1%)	72 (78.3%)	N.S.
If yes, who makes the final decision?			
* Husband	16 (9.3%)	12 (8.6%)	N.S.
* Wife	6 (3.5%)	6 (3.8%)	
* Both	150 (87.2%)	140 (88.6%)	

N.S. = Not Significant

Table 10:
Showing Strategies for Achieving the Desire to Plan Family

Strategies	Sex of Respondents		
	Male n= 190	Female n= 164	P-value for Yates _{corrected} χ^2
Use family planning contraception	170 (36.8%)	80 (48.8%)	N.S.
Abstain from sexual intercourse when it is not safe	100 (52.6%)	52 (31.7%)	0.00003
Use come charms/herbs	6 (3.2%)	10 (6.1%)	N.S.
God's help	56 (29.5%)	40 (24.3%)	N.S.

N.S. = Not Significant

Table 11:
**Approval of Marital Partner's Use of Contraceptive
Materials to Prevent Unwanted Pregnancy**

Contraceptive Materials	Sex of Respondents		
	Male	Female	P-value for Yates _{corrected} χ^2
Condom	74 (29.8%)	90 (36.3%)	N.S.
Contraceptive pills	30 (12.1%)	46 (18.4%)	N.S.
Abstinence	22 (8.9%)	30 (12.0%)	N.S.
Charms/herbs	140 (56.5%)	142 (56.8%)	N.S.
Charms/herbs	28 (11.6%)	12 (5.4%)	0.03